



Office of Equity and Inclusion
Health Equity Workforce Program

Traditional Health Worker Full Certification Application

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English. To request this publication in another format or language, contact thw.program@state.or.us.

Please type or clearly print the completed form. Complete and send all the following information by mail:

Traditional Health Worker Program

OHA Office of Equity and Inclusion

421 S.W. Oak St., Suite 750

Portland OR 97204

Email thw.program@state.or.us or fax: 971-673-1128

Traditional health workers include the following worker types:

- *Community health workers (CHW);*
- *Peer support specialists (PSS);*
- *Peer wellness specialists (PWS);*
- *Personal health navigators (NAV); and*
- *Birth doulas.*

If you are one of these worker types and want to be certified as a traditional health worker (THW), you must submit this completed application and all necessary documents to the Oregon Health Authority (OHA).

Complete this application if you meet all of the following requirements. You:

- Are at least 18 years of age;
- Are not on the Medicaid exclusion list; and
- Have finished all required training for your worker type. Your training must be through an OHA-approved training program.

You must also do these things when you seek a THW certification. Submit:

- A clear copy of a driver's license, state-issued ID card or passport for your background check.
- A copy of your training certificate; and
- A completed application.

Criminal background check process

The OHA Office of Equity and Inclusion (OEI) will send your name to the Background Check Unit (BCU). The BCU will send you an email requiring you to complete a Background Check application. You may be asked to submit fingerprints; OEI will notify you by email if fingerprints are required.

For more information about the background check, go to [THW Background Check Weighing Test](#).

Completing the process

If OHA confirms you have met all requirements, OHA will notify you in writing of your certification as a THW. OHA will add your name and contact information to the registry of certified THWs.

OHA Use Only

Section 1: Basic information

1.1 Application type: Full certification *Grandfathering (see note under 1.3b)
 Renewal (must have 20 CEUs and apply within 30 days of expiration)

Primary worker type (check one) CHW NAV Birth doula
 PWS type: addictions mental health family peer youth
 PSS type: addictions mental health family peer youth

In your role, you expect direct contact with (check all that apply):

- Children Adults Seniors (65 years and older)
 Confidential information Finances/financial records
 Secure facilities Information technology systems

In your role, do you expect to drive? Yes No

1.2 Applicant contact information

First name: _____ Last name: _____ Date of birth: / / _____

Mailing address _____

City _____ State _____ ZIP _____

Preferred contact number _____ Email _____

Make the following information available on the Certified THW Registry: Check all that apply, or "none" to have name only visible (no contact info visible).

Address Phone Email None

Section 1.3: Training Information

1.3a Training type

Check the type of training program that you have completed.

- OHA-approved CHW, PWS, PSS, NAV Core Curriculum Training
 OHA-approved Incumbent Worker Training
 OHA-approved Birth Doula Training
 DONA or ALACE Doula Certification **and** six hours of OHA-approved Cultural Competency Training

1.3b Proof of training completion

Attach proof of completion of the training program checked above.

***Grandfather clause:** The training requirement may be waived when you provide proof of having worked or volunteered as a CHW/PWS/NAV in Oregon for at least 3,000 hours within five years of the date of this application.

1.3c OHA-approved training program Information

Fill out the following information about the OHA-approved training program you completed.

Name of organization _____

/ / - / /

Official name of training program _____

Training start and end Dates _____

Section 2: Demographic and availability information

You can choose whether or not to complete this section; it will have no impact on certification.

2.1 Race and ethnicity (*check one*):

A. Racial or Ethnic Identity

✓ Check ONE for PRIMARY racial/ethnic identity

Circle all that apply to your identity

1 = American Indian/Alaska Native

1.1 = American Indian

1.2 = Alaska Native

1.3 = Canadian Inuit, Metis or First Nation

2 = Hispanic, Latino

2.1 = Indigenous Mexican, Central American or South American

2.2 = Hispanic or Latino Mexican

2.3 = Hispanic or Latino Central American

2.4 = Hispanic or Latino South American

2.5 = Other Hispanic or Latino—specify

3 = Asian

3.1 = Chinese

3.2 = Vietnamese

3.3 = Korean

3.4 = Hmong

3.5 = Laotian

3.6 = Filipino/a

3.7 = Japanese

3.8 = South Asian

3.9 = Asian Indian

3.10 = Other Asian—specify

4 = Pacific Islander

4.1 = Native Hawaiian

4.2 = Guamanian or Chamorro

4.3 = Samoan

4.4 = Micronesian

4.5 = Tongan

4.6 = Other Pacific Islander—specify

5 = African /African American/ Black

5.1 = African American

5.2 = African

5.3 = Caribbean

**5.4 = Other African/African
American/Black—specify**

6 = White

6.1 = Western European

6.2 = Eastern European

6.3 = Slavic

6.4 = Middle Eastern

6.5 = Northern African

6.6 = Other White—specify

7. Unknown

8. Decline to answer

2.2 Gender, Orientation, and Disability

B. Gender Identity (Circle one)

B1 = Male

B2 = Female

B3 = Transgender

B4 = Something else—specify _____

C. Sexual Orientation (Circle one)

C1 = Gay or lesbian

C2 = Straight, not gay or lesbian

C3 = Bisexual

C4 = Queer

C5 = Something else—specify

D. Disability (Circle all that apply)

D1 = Deaf or serious difficulty hearing

D2 = Blind or serious difficulty seeing even when wearing glasses

D3 = Serious difficulty concentrating, remembering, understanding, or making decisions (due to a physical, mental, or emotional condition)

D4 = Serious difficulty walking or climbing stairs

D5 = Difficulty dressing or bathing

D6 = Difficulty doing errands alone (such as doctor's visits or shopping)

D7 = Something else—specify _____

2.3 Language(s) that you speak and write well, including English:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> African Languages:
(Specify) _____ | <input type="checkbox"/> Hmong | <input type="checkbox"/> Mien | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Indic:
(Specify) _____ | <input type="checkbox"/> Mon-Khmer, Cambodian | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian | <input type="checkbox"/> Persian | <input type="checkbox"/> Thai |
| <input type="checkbox"/> English | <input type="checkbox"/> Japanese | <input type="checkbox"/> Russian | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> French | <input type="checkbox"/> Korean | <input type="checkbox"/> Scandinavian:
(Specify) _____ | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> German | <input type="checkbox"/> Lao | <input type="checkbox"/> Slavic:
(Specify) _____ | <input type="checkbox"/> Sign Language:
(Specify) _____ |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Marshallese | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other:
(Specify) _____ |

2.4 Geographic availability Where are you willing to work? (Choose as many locations as desired. Check with or)

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
<input type="checkbox"/> Clatsop	<input type="checkbox"/> Clackamas	<input type="checkbox"/> Yamhill	<input type="checkbox"/> Coos	<input type="checkbox"/> Curry	<input type="checkbox"/> Hood River	<input type="checkbox"/> Crook	<input type="checkbox"/> Baker
<input type="checkbox"/> Columbia	<input type="checkbox"/> Multnomah	<input type="checkbox"/> Polk	<input type="checkbox"/> Douglas	<input type="checkbox"/> Jackson	<input type="checkbox"/> Gilliam	<input type="checkbox"/> Deschutes	<input type="checkbox"/> Harney
<input type="checkbox"/> Tillamook	<input type="checkbox"/> Washington	<input type="checkbox"/> Marion	<input type="checkbox"/> Lane	<input type="checkbox"/> Josephine	<input type="checkbox"/> Sherman	<input type="checkbox"/> Grant	<input type="checkbox"/> Malheur
		<input type="checkbox"/> Benton	<input type="checkbox"/> Linn		<input type="checkbox"/> Klamath	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Morrow
		<input type="checkbox"/> Lincoln				<input type="checkbox"/> Lake	<input type="checkbox"/> Umatilla
						<input type="checkbox"/> Wasco	<input type="checkbox"/> Union
						<input type="checkbox"/> Wheeler	<input type="checkbox"/> Wallowa

2.5 Work schedule availability:

Days available: (Check all that apply.)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Sunday | <input type="checkbox"/> Monday |
| <input type="checkbox"/> Tuesday | <input type="checkbox"/> Wednesday |
| <input type="checkbox"/> Thursday | <input type="checkbox"/> Friday |
| <input type="checkbox"/> Saturday | |

Hours of availability: (Check all that apply.)

- | | |
|----------------------------------|-------------------|
| <input type="checkbox"/> Day | 7 a.m. – 5 p.m. |
| <input type="checkbox"/> Evening | 5 p.m. – midnight |
| <input type="checkbox"/> Night | Midnight – 7 a.m. |

Are you available to the public? (to provide services):

- Yes No

Section 3: Code of ethics and signature

Please read the following statements carefully. Indicate your understanding and acceptance by signing below.

I agree to abide by the training and certification rules, and traditional health worker standards of professional conduct. Refer to Oregon Administrative Rules (OAR) 410-181-0300 through 410-180-0388.

I understand that Oregon Health Authority (OHA) may deny, suspend or revoke certification status if I do not comply with Oregon Revised Statute (ORS) 414.665 or OAR 410-181-0300 through 410-180-0388.

I understand that I must apply to renew my certification status every three years. I must submit the renewal application no less than 30 days before my current certification period ends. I understand I will be removed from the registry if I fail to renew my certification within the renewal period. If I choose not to renew certification, I agree not to represent myself to potential employers or clients as a certified THW.

I certify that all the information contained in this application is true and accurate to the best of my knowledge and understanding. I understand that my application may be denied or my certification may be revoked if I give false, incomplete or misleading information.

Print name: _____

Signature: _____ Date: _____